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ABSTRACT

This document provides guidelines for clinicians working with gifted, suicidal adolescents. It addresses: (1) the need to set limits in the early sessions of psychotherapy; (2) the necessity of maintaining a presence by making personal sacrifices through being accessible, talking on the phone, scheduling extra sessions and, in extreme cases, visiting the adolescents in the community; (3) enforcing therapeutic limits by using an active crisis intervention model that protects the adolescent from harm; (4) working with families in an outpatient setting to help parents protect their children from self-harm; (5) informing the youth that there will be disclosure to third parties when there is a threat of personal harm or violence; (6) maintaining therapeutic perspective when attempting to stabilize self-annihilative behavior; (7) instilling hope in the future and decreasing chances of future suicidal acts; (8) dealing with death of an adolescent; (9) helping an adolescent reclaim his or her life by regaining self-respect; and (10) terminating the treatment relationship. (Contains 41 references.) (CR)

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Guidelines for Clinicians Working with Gifted, Suicidal Adolescents.

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MHJ: Guidelines for Clinicians Working with Gifted, Suicidal Adolescents

by Thomas E. Bratter, Ed.D.

January 1997

Adolescents are among the most difficult populations with whom to work therapeutically. Giovacchini (1985) wrote that they possess a "propensity for creating problems within the treatment setting [including]...their reticence about becoming engaged or their inclination to express themselves through action rather than words and feelings."

Only a minuscule number of psychotherapists opt to work with these patients, whose problems may be giftedness, drug-dependence and/or self-destructive tendencies, up to and including suicide. Meeks and Bernet write that "the drama and finality of suicide conspire with the personality traits of suicidal youngsters to make treating the suicidal adolescent one of the psychotherapist's most exacting experiences."

There are two unalterable clinical realities working with suicidal adolescents. Rule One: Some will die of drug overdoses, commit suicide or be murdered. Rule Two: There will be cases when concerned clinicians cannot change Rule One.

Not infrequently, suicides occur in inpatient psychiatric programs having 24-hour surveillance. Maltsberger (1992, 1986) offers a partial explanation of why work with these adolescents cannot always be successful when he concludes that no test exists and no single variable exists to predict suicide. Kernberg urges the psychotherapist to "assess the degree of hopelessness...[that] plays a most important role as a predictor of risk [when the therapist experiences] a sense of pessimism about the treatment and about the patient, and his/her own therapeutic skills."

Samorajczyk writes that alienated youngsters "want to know where the limits are—and that someone gives a damn" to guide them in their search for what is expected of them. When there is fear that the adolescent is out of control and might harm him/herself, most psychotherapists and psychoanalysts, choosing not to become more humanistic, active-directive and pragmatic, will be impotent in providing the limit-setting that suicidal adolescents desperately need.

Since suicidal, drug-dependent adolescents engage in illicit behavior, they trust no one. Initially, the therapist is viewed to be a formidable foe who possesses the power either to force them to terminate pleasurable drug-induced euphoria or to incarcerate them.

While describing working with suicidal adolescents, Jobes contends a negative transference dynamic exists because "the clinician is...seen as a member of the...generation from which the adolescent seeks autonomy, and a teen's associations [with] seeing a 'doctor' or a 'shrink' may have a long history that can be antagonistic to the kind of relationship needed for good treatment."

Until the therapist accepts the mandate to prove personal credibility, alienated adolescents neither will like nor trust the therapist who becomes a target for their unmitigated hostility and sarcasm. To protect themselves from being wounded, such adolescents often project an antagonistic, obnoxious attitude before acquiescing to treatment.

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Early Sessions: Limit-Setting

Limit-setting forms the basis of the therapeutic alliance during the first month. Masterson maintains it is "impossible to wait for a relationship to be established before starting to set limits...as early as possible, [which] is the unique means of establishing the therapeutic alliance and...is the very gesture of caring the patient hungers for."

The therapist can have no ambivalence in a life-or-death crisis. Any hesitation can be fatal. Until the adolescent fears intervention by the treatment agent or feels hope for the diminution of pain often caused by impulsive acts, he or she will have no incentive to change. Initially, the clinical challenge is to decrease life-threatening behavior by enforcing compliance, which makes therapy tumultuous.

During the potentially lethal phase of treatment when the adolescent is out of control, the psychotherapist needs to be decisive to decrease the possibility of impulsive, annihilative suicidal acts. Desperate, often heroic limit-setting therapeutic strategies are necessary. The most controversial point in the treatment relationship occurs when the psychotherapist imposes him- or herself as the central figure by determining therapeutic limits.

Understandably, most psychotherapists are uncomfortable with this treatment orientation, but given the special clinical challenges of suicidal adolescents, this is not negotiable during the beginning phase of treatment. It becomes the sine qua non of therapeutic behavior necessary to maximize survival. Schneidman states:

> The way to save a suicidal person is to cater to that individual's infantile and realistic idiosyncratic needs. The suicide therapist should, in addition to other roles, act as an existential social worker, a practical person knowledgeable about realistic resources. The therapist needs to work diligently, always giving the suicidal person realistic transfusions of hope, until the perturbation intensity subsides enough to reduce the lethality to a tolerable, life-permitting level.

Maintaining a Presence

Working with self-destructive or suicidal adolescents whose crises occur at times other than appointments can create scheduling problems by necessitating missing sessions with others and disrupting one's personal life. When the therapist vacations, continued communication and continuity are crucial, as Motto points out, "to maintain the psychological sense of 'presence'...to demonstrate...[that] the therapist's concern for the young person is not limited...One of the most common circumstances for suicidal acting out is when the therapist is away...[because] it can so easily stir the fears and feelings of abandonment that generate suicidal impulses."

Unless the therapist is prepared to make personal sacrifices by being accessible, by talking on the phone, scheduling extra sessions and, in extreme cases, visiting the adolescent in the community, this treatment population needs to be avoided. Until the crises abate, accessibility is required on a 24-hour, seven-day-a-week basis.

When anticipating being inaccessible, if possible, the psychotherapist needs to introduce the adolescent to the covering professional and make provisions to be reached by phone either by providing a number or arranging for notification through the answering service should a potential emergency or crisis arise. It needs to be stressed that survival of the adolescent precedes transference-countertransference issues.

The burden to convince suicidal, alcohol and drug-addicted adolescents to return for the next session is a crucial clinical challenge. A simultaneous goal would be to persuade the adolescent to begin not only to trust but also to believe that the credentialed professional possesses the power to force him or her to cease all drug-related activities.

Initially, there can be no therapeutic continuity because self-annihilative adolescents are volatile. It becomes difficult to formulate intermediate or long-term psychotherapeutic goals, other than survival. Treatment difficulties may be further compounded in the case of gifted, self-destructive adolescents exiled by their families for disrespectful and illicit behavior, expelled from high school or college, devastated by the loss of a significant relationship, and/or subjected to legal consequences or assaulted by drug associates.

A Model of Protection

It is important not only to define therapeutic limits but also to enforce them by using an active crisis intervention model that protects the adolescent from harm. A direct crisis-intervention approach assumes suicide can be prevented; otherwise, inpatient treatment must be sought.

Sometimes, at-risk adolescents miss a session to test limits. Sometimes, they arrive intoxicated, creating an immediate treatment crisis that needs to be resolved. The therapist must decide whether to cancel the session or continue. If, however, the therapist decides to continue the meeting, the implicit message can be condonement of confirmed drug abuse.

Issues of Confidentiality

Confidentiality is an important issue. The psychotherapist needs to inform the youth there will be disclosure to third parties when there is a threat of personal harm or violence. Shneidman recommends a kind of "modification of...confidentiality" since the therapist cannot be allied with death. Statements given during the therapy session relating to the patient's overt suicidal (or homicidal) plans are not "a secret between two collusive partners." A written agreement can clearly detail the therapist's policy about confidentiality and disclosure. For instance, my agreement with patients reads:

> Our relationship is confidential, protected by the ethics of the American Psychological Association and statutes of Massachusetts. There are, however, three exceptions when I have a moral and legal duty to inform others: when you (1) discuss your intent to harm someone; (2) inform me you consider hurting yourself; and (3) describe a future illicit act. While your interests and welfare are my primary concerns, when believing you want to hurt yourself or others, I will intervene.
>
> Please sign signifying you understand the three provisions stated herein. If you cannot agree to this arrangement, then it makes sense for you to work with someone else. If you violate this contact by not discussing your behavior with me before you act, I reserve the right to terminate our relationship.
>
> name: _____
>
> witness: _____
>
> date: _____

In my three-and-a-half decades of working with gifted, self-destructive, drug-dependent adolescents, I have not seen them discuss future self-destructive or illegal acts unless they want to be restrained. Their disclosure, therefore, can be interpreted to be a plea for external control. A firm, rational discourse provides reassurance that there will be limit-setting to the healthy part of the adolescent that wants to live.

The Family

Robinson believes working with families in an outpatient setting to be "important, particularly when the child's suicidal state is reactive to inappropriate parental behavior" that explicitly suggests disclosing information about self-destructive acts. Parents have the ultimate responsibility to protect their children from self-harm. The psychotherapist who does not attempt to elicit external assistance for self-destructive behavior could be accused of not trying every resource to contain the adolescent's self-destructive behavior. By helping the youth gain the resolve to control and curtail such behavior, the psychotherapist is placed in a position of parental surrogate. Bonding occurs concurrently with therapeutic interventions to limit potentially explosive self-hatred, shame, devastation and rage, because the therapist becomes the "good parent" who protects the adolescent from self-harm.

Sometimes the family of the suicidal adolescent is so dysfunctional it may not be possible to include members as part of the treatment team. Leenas and Lester urge caution involving the family, saying "the system is often inflexible. Denial, secretiveness and especially a lack of communication are seen."

Psychotherapeutic Approaches

During the course of therapy with suicide-prone adolescents, the therapeutic mandate is to maximize the chances of survival. Any neglect of that task will appear to the patient to be the ultimate irresponsible, noncaring act.

Working with impulsive adolescents who engage in death-defying behavior runs contrary to Szasz's advice "not to show that you are humane, that you care for [the patient]...Your sole responsibility is to analyze him." Wachtel presents a more moderate view of therapeutic neutrality which is designed "to assure that we do not muddy the waters of transference...We are always observing something that occurs in relation to us, and not just to us as screens or phantoms, but to us as...flesh-and-blood human beings sitting in the consultation room."

Jobes recommends rejecting the dynamic approach when working with suicidal adolescents. The suicidal adolescent, Laufer (1995) writes, "urgently needs skilled help and understanding, so that he feels less alone with his...determined belief that to be dead is the only answer...Unsuitable help or superficial caring is much more harmful than no help at all during the crisis period. No help, rather than inappropriate help, leaves open the hope that there may be a caring person nearby, but inappropriate help is experienced as confirmation that he can die, because nobody cares."

Symbolically sinking in quicksand, the adolescent will drown unless there is heroic intervention by the psychotherapist. Therapists who worry about the ramifications of disturbing the transference-countertransference formation must recognize that unless they intervene, death is absolute.

The most important countertransference task is to maintain therapeutic perspective when attempting to stabilize self-annihilative behavior. The therapist must remain a rational and responsible restraining force by questioning personal motives, e.g.: Do I become excessively angry when disappointed or disobeyed? Do I wish to punish when feeling frustrated? Do I hate or wish to replace parents? Do I feel I am owed respect, appreciation and compliance? Do I feel relief when the adolescent cancels an appointment? Do I hope the relationship ends?

Therapeutic Responsibilities

Substance-abusing suicidal adolescents seek immediate gratification and relief. Consequently, they demand the psychotherapist produce results. Initially, the charisma of the mental health worker may be the primary reason to live because not infrequently everyone, including the adolescent, has conceded there is little hope for recovery. By conscious choices these adolescents have trapped themselves in a painful labyrinth where expectations of failure, rejection, mistrust, pain and loneliness become self-fulfilling prophesies. The youth may feel so overwhelmed and dejected that death may appear the most viable escape.

Joffee posits, "When adolescents feel...out of control, vulnerable and helpless, the idea of suicide gives them a sense of power over their...lives and a weapon to be used against others. It enables them to nurse a fantasy in which it is the parent or therapist who is seen to be-and, indeed, is made to feel-impotent and helpless."

The therapists' task is to instill hope in the future. After the treatment agent has been convinced by the adolescent that the threat of death has been diminished, an aggressive advocate stance helps to restore hope and decreases the chances of future suicidal acts. Expectations on the part of the patient for the psychotherapist to function as a personal advocate may be the initial motivation to enter into therapy. The act of advocacy permits the psychotherapist to maintain expectations for growth."

Finally, because some adolescents require more time before they begin to realize their potential, the credentialed professional must have an indefatigably optimistic and idealistic attitude never to give up or to quit.

Reactions to Death

Undeniably, suicide is an occupational hazard which confronts the psychotherapist who works with self-destructive adolescents. Goldstein and Buongiorno interviewed 20 psychotherapists who had patients commit suicide and reported that the therapists were permanently affected in two ways: first, the experience remained vividly in their minds; second, they tended to no longer minimize suicidal behavior, attempts and gestures.

Giovacchini (1992) further suggests that adolescents can provoke disruptive countertransference reactions, because "the intensity of their neediness and defiance may completely dominate the therapeutic setting and disrupt the orderly course of treatment...Countertransference may destroy the treatment relationship or it may lead to therapeutically beneficial insights."

My reaction to the death of an adolescent, whether by an act of suicide or homicide, is profound self-condemnation. I curse my ignorance, impotence and incompetence any or all of which may have contributed to death.

While painful and humbling, any ex post facto investigation not only purges guilt, but also enables the therapist to devise strategies that may be utilized in other life-threatening crises. Winnicott suggests, "If an analyst is to analyze psychotics or antisocials, he must be able to be so thoroughly aware of the countertransference that he can sort out and study his objective reactions to the patient. These will include hate."

The "adoptive process" in the residential treatment of adolescents has been viewed as the acting out of a rescue fantasy on the part of professionals who have not resolved their adolescent conflicts or who seek to become parental surrogates due to unfulfilled personal needs (Palmer and colleagues).

Shay attributes the need to rescue to an unforgotten, unresolved countertransferential reaction:

> When we were teens, many of us were concerned with where we stood with our peers...With our newfound sexual yearnings, many of us had the developmentally appropriate wish to...be adored...As we aged, we made peace with these needs as we shaped our identities, found groups to include us, found significant others to love us...The wish to belong, the yearning to be admired, the need to feel loved are frequently revived by our...patients who live these issues passionately every day...To borrow a phrase, "We have met the adolescent, and he is us."
>
> If one accepts this notion of an inherent over-identification with our adolescent patients, then the countertransference wish to rescue them is...comprehensible. It is something like the Golden Rule of Countertransference: Rescue others as you would have liked to be rescued yourself.

Certainly, the rescue pattern plays a part in my life. My recurring dream has been described best by J.D. Salinger in *The Catcher in the Rye* when he wrote about Holden's fantasy preoccupation:

> I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody's around-nobody big, I mean-except me. And I'm standing on the edge of some crazy cliff. What I have to do. I have to catch everybody if they start to go over the cliff-I mean if they're running and they don't look where they're going. I have to come out from somewhere and catch them. That's all I'd do all day. I'd just be the catcher in the rye and all. I know it's crazy, but that's the only thing I'd really like to be.

For me, the clinical challenge is to prevent the adolescent from falling over the "crazy cliff" that symbolizes destruction and death. I dread thinking about those who committed suicide or were murdered. It has proven beneficial, in retrospect, because I have the courage and resilience to examine what I could have done differently. I have strength to remain involved with those self-destructive,

drug-dependent adolescents with whom I struggle to help to survive.

Psychotherapists who do not dream about rescue fantasies need to disqualify themselves from working with gifted, suicidal, drug-dependent adolescents because, without heroic therapeutic intervention, the probability of injury and death is increased significantly with intervention.

The Adolescent and Self-Respect

There can be no finer reward than trying to help an adolescent reclaim his or her life by regaining self-respect, a primary psychotherapeutic goal. Bratter and others (1995) describe a therapeutic definition of self-respect which stresses: the concept of choice based on humanistic values that include concern for others and a sense of social responsibility, honesty and the integrity to be assertive. The adolescent needs to behave in a congruent way to achieve immediate to long-term personal-professional goals without depriving others of their rights.

Saying Good-Bye

Perhaps one of the most crucial developmental tasks of self-respect is to help the adolescent terminate the bonds of dependency and become autonomous. "Setting free" means free to terminate the treatment relationship with no pressure either to return or to be grateful. Saying good-bye can be liberating, but the adolescent retains the option to correspond or communicate periodically. This can be encouraged provided it primarily satisfies the needs of the adolescent, not those of the therapist.

The termination is similar to all treatment relationships with adolescents. Should the psychotherapist encounter difficulty or feel entitled to continue the relationship, this needs to be resolved because it signals a countertransference problem exists. The adolescent does not owe the psychotherapist anything.

Dr. Bratter is president-founder of the John Dewey Academy. The residential, college preparatory high school offers treatment for gifted, self-destructive adolescents aged 15 to 21. It is located in Great Barrington, Mass.

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